# *YELM FAMILY MEDICINE*

Authorization to Use or Disclose Health Care Information

Patient Name:_____DOB:_____

Previous Name:_____SS#_____

**I. My Authorization**

**You may use or disclose the following health care information (check all that apply):**

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: _____
- ☐ Health care information in my medical record for the date (s):_____
- ☐ Other (e.g., X rays, bills), specify date (s):_____

**EXCLUDE the following information from the records released (Please initial):**

- ☐ HIV (AIDS virus)
- ☐ Psychiatric disorder/mental health
- ☐ Sexually transmitted diseases
- ☐ Drug and/or alcohol use

| **I request and authorize:** | **To release my records to:** |
|---|---|
| Clinic/Provider Name:_____ | Yelm Family Medicine |
| Address:_____ | PO BOX 760 |
| City:_____State:_____Zip:_____ | Yelm WA, 98597 |
| Phone:_____Fax:_____ | Ph.(360)458-7761/fax (360)458-6612 |

**Reason(s) for this authorization (check all that apply):**

- ☐ at my request
- ☐ physician request
- ☐ attorney request
- ☐ other (specify) _____

**This authorization ends:** (*This document does not permit disclosure of health information created more than 90 days after the date it is signed.)*

- ☐ *i*n 90 days from the date signed
- ☐ on (date): _____
- ☐ when the following event occurs: _____ (no longer than 90 days from date signed)

**II. My Rights**

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment.) However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would affect any actions already taken by Yelm Family Medicine based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

**1.** Fill out a revocation form. A form is available from Yelm Family Medicine Or

**2.** Write a letter to Yelm Family Medicine

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____

Patient or legally authorized individual signature Date Time

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal rep.)

**LAST UPDATE 3-10-05**